APPENDIX A
DECISION OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT
AUGUST 16, 2006

United States Court of Appeals,
Fifth Circuit.

LOUISIANA HEALTH SERVICE & INDEMNITY CO., d/b/a Blue Cross and Blue Shield of Louisiana, Plaintiff-Intervenor Defendant-Appellant,

v.

RAPIDES HEALTHCARE SYSTEM; State of Louisiana; Charles R. Foti, Jr., Attorney General for the State of Louisiana, Defendants-Appellees,

v.

Dauterive Hospital, Intervenor Defendant-Appellee.

No. 04-31114.

461 F.3d 529

Aug. 16, 2006.

Appeal from the United States District Court for the Middle District of Louisiana.

Before HIGGINBOTHAM, DeMOSS and OWEN, Circuit Judges.

PATRICK E. HIGGINBOTHAM, Circuit Judge:

Section 40:2010 of the Louisiana Revised Statutes requires insurance companies to honor all assignments of benefit claims made by patients to hospitals. This case asks us to decide whether the Employee Retirement Income Security Act of 1974 preempts the assignment statute to the extent

that it applies to fully insured ERISA plans. We hold that Louisiana's assignment statute is not preempted.

I

The relevant facts in this case are undisputed. Section 40:210 [sic] of the Louisiana Revised Statutes (the "assignment statute") provides, in relevant part:
Itemized statement of billed services by hospitals.

... No insurance company, employee benefit trust, self-insurance plan, or other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered***531** by the hospital shall pay those benefits to the individual when the itemized statement submitted to such entity clearly indicates that the individual's rights to those benefits have been assigned to the hospital. When any insurance company, employee benefit trust, self-insurance plan, or other entity has notice of such assignment prior to such payment, any payment to the insured shall not release that entity from liability to the hospital to which the benefits have been assigned, nor shall such payment be a defense to any action by the hospital against the entity to collect the assigned benefits.[1]

The assignment statute is included in the "State Department of Hospitals" chapter of Louisiana's Public Health and Safety code. As the title indicates, the statute imposes various additional requirements on hospitals regarding itemized statements of billed services to patients. Those requirements are not at issue in this case.

Two hospitals, defendant Rapides Health Care System and intervenor Dauterive Hospital (collectively, "the Hospitals"),

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[1] La.Rev.Stat. Ann. § 40:2010 (2004).

complained to the Louisiana Department of Insurance ("DOI") that Louisiana Health Service & Indemnity Co., d/b/a Blue Cross and Blue Shield of Louisiana, failed to comply with the assignment statute after the Hospitals terminated their participating provider agreements with Blue Cross. While the DOI investigated the complaints, ultimately concluding that Blue Cross's policy provisions violated the assignment statute, Blue Cross filed the present case against Rapides, the State of Louisiana, and the Louisiana attorney general, seeking a declaration that the assignment statute is preempted by ERISA to the extent that it applies to ERISA employee welfare benefit plans insured or administered by Blue Cross. Dauterive intervened.

All health insurance plans issued and administered by Blue Cross contain provisions governing the assignment of benefits. The parties agree that all provisions are substantially similar to the following:

Direct Payment to Member

1. All benefits payable by the Company [Blue Cross] under this Benefit Plan and any amendment hereto are personal to the Member and are not assignable in whole or in part by the Member. The Company has the right to make payment to a Hospital, Physician, or other Provider (instead of to the member) for Covered Services which they provided while there is in effect between the Company and any such Hospital, Physician, or other Provider an agreement calling for the Company to make payment directly to them. In the absence of an agreement for direct payment, the Company will pay to the Member and only the Member those Benefits called for herein and the Company will not recognize a member's attempted assignment to, or direction to pay, another, except as required by law.

* * *

3. If the Company has offered a Hospital, Physician, or other Provider an agreement for direct payment by the Company, but there is no such agreement in effect when Covered Services are rendered to a Member by such Hospital, Physician, or other Provider, the Company will not recognize a Member's attempted assignment to, or direction to pay, such Hospital, Physician, or other Provider. The Company will pay to the Member and only the Member ***532** those Benefits called for in this Benefit Plan and any amendment thereto.

Blue Cross divides hospitals into "participating providers" and "nonparticipating providers." Blue Cross's agreement with participating providers includes a provision allowing or requiring direct payment to the provider. With nonparticipating providers, there is no agreement, and, pursuant to the above language, Blue Cross will not honor a patient's assignment of benefits to the provider. The burden is then on the nonparticipating provider to collect its fees directly from the patient. Blue Cross does not dispute that its refusal to honor assignments to nonparticipating providers violates the assignment statute.

Blue Cross moved for summary judgment on the ERISA preemption issue in August 2001. Finding only an indirect economic effect on ERISA plans, the district court denied summary judgment, reasoning that the assignment statute "facilitate[d] and promote[d] the goals of ERISA" and that it was a health-care regulation within an area of state law that Congress did not intend to preempt. As such, the district court did not need to consider whether the statute was saved from preemption as a law regulating insurance. In the alternative, the court concluded that the language of Blue

Cross's health care plan requires compliance, because the anti-assignment provision says that such assignments will not be honored "except as required by law."[2]

Over the next two years, Blue Cross and the Hospitals litigated various other claims that were later settled and are not at issue on appeal. In June 2004, both parties filed motions for summary judgment on the preemption issue. Blue Cross argued that the Supreme Court's intervening decision in *Aetna Health Inc. v. Davila* [3] and the Third Circuit's decision in *Barber v. UNUM Life Insurance Co.* [4] required preemption of the assignment statute because it conflicted with the exclusive enforcement provision in ERISA. Adopting its previous ruling and reasoning, the district court denied Blue Cross's motion and granted the motions filed by the State of Louisiana and the Hospitals. The court concluded that because ERISA is silent regarding assignment of health benefits, the assignment statute does not alter an existing ERISA provision and, thus, was not conflict preempted. The court distinguished *Davila* and *Barber* as cases involving state statutes that altered existing ERISA provisions. Blue Cross timely appealed. We have jurisdiction under 28 U.S.C. § 1291.

II

First, we address whether the plain language of Blue Cross's ERISA plans requires compliance with the assignment statute. If so, then we would not need to reach the preemption questions. [5] If the ERISA plans at issue do not

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[2] *La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 213 F.Supp.2d 650 (M.D.La.2002) (Brady, J.).

[3] 542 U.S. 200, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004).

[4] 383 F.3d 134 (3d Cir.2004).

[5] *See Arana v. Ochsner Health Plan*, 352 F.3d 973, 976 (5th Cir.2003) (declining to reach preemption question where no conflict existed); *see*

require compliance with the assignment statute, then we must address Blue Cross's two-prong preemption attack. Blue Cross contends, first, that the assignment statute is ***533** preempted because it conflicts with ERISA's exclusive enforcement scheme. [6] Second, Blue Cross contends that the assignment statute is preempted as a statute that "relate[s] to" ERISA. [7] Finally, should we conclude that the assignment statute is preempted as a statute that relates to ERISA, we must determine whether it is "saved" from preemption as a law regulating insurance.[8] Our review is *de novo*. [9]

A

Attempting to displace the preemption issue, the Hospitals contend that there is no conflict between Blue Cross's ERISA plans and the assignment statute because the plan prohibits assignments "except as required by law." The Hospitals contend that this language modifies the express plan terms to require compliance with Louisiana's assignment statute. Blue Cross argues that this provision is trumped by a subsequent provision of the policy, which states that the plan is governed by Louisiana law "except when preempted by federal law." The district court agreed with the Hospitals, concluding that Blue Cross's policy provisions are "automatically amended ... to conform to the requirements"

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also Ashwander v. Tenn. Valley Authority, 297 U.S. 288, 347, 56 S.Ct. 466, 80 L.Ed. 688 (1936) (Brandeis, J., concurring) ("The Court will not pass upon a constitutional question although properly presented by the record, if there is also present some other ground upon which the case may be disposed of.").

[6] Employee Retirement Income Security Act of 1974 § 502(a), 29 U.S.C. § 1132(a) (2004).

[7] *Id.* § 514(a), 29 U.S.C. § 1144(a).

[8] *Id.* § 514(b)(1)(A), 29 U.S.C. § 1144(b)(1)(A).

[9] *Provident Life & Accident Ins. Co. v. Sharpless*, 364 F.3d 634, 640 (5th Cir.2004); *Frank v. Delta Airlines, Inc.*, 314 F.3d 195, 197 (5th Cir.2002).

of the assignment statute. [10]

[1] We disagree. Neither policy provision displaces the preemption analysis in this case. ERISA plans must always conform to state law, but only state law that is valid and not preempted by ERISA. The presence of the phrase "except as preempted by law" serves no additional purpose, as all state laws are potentially subject to ERISA's preemptive force. The two provisions do not forestall determination of the preemption question. To that, we now turn.

[2] Article VI's Supremacy Clause may entail preemption of state law in any of three ways: by express provision, by implication, or by a conflict between state and federal law. [11] Blue Cross advances two separate preemption arguments: first, Blue Cross contends that Louisiana's assignment statute conflicts with ERISA's exclusive enforcement scheme; second, Blue Cross contends that the assignment statute is expressly preempted as it is a law that "relate[s] to" employee benefit plans. Neither argument persuades.

I

[3][4] Under general principles of conflict preemption, a law is preempted "to the extent that it actually conflicts with federal law," [12] that is, when it is impossible to comply with both state and federal law. [13] Further, a state law is conflict ***534** preempted when it "stands as an obstacle to the

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[10] *La. Health Svc. & Indem. Co.*, 213 F.Supp.2d at 657.

[11] *See Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 203-04, 103 S.Ct. 1713, 75 L.Ed.2d 752 (1983); *Rice*, 331 U.S. at 230, 67 S.Ct. 1146.

[12] *English v. Gen. Elec. Co.*, 496 U.S. 72, 79, 110 S.Ct. 2270, 110 L.Ed.2d 65 (1990).

[13] *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248, 104 S.Ct. 615, 78 L.Ed.2d 443 (1984); *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43, 83 S.Ct. 1210, 10 L.Ed.2d 248 (1963).

accomplishment and execution of the full purposes and objectives of Congress."[14]

In *Aetna Health Inc. v. Davila,* the Supreme Court reaffirmed that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted."[15] *Davila* involved a Texas statute that created a cause of action for any person injured by a plan administrator's failure to exercise ordinary care in the handling of coverage decisions. Recognizing ERISA's " 'comprehensive legislative scheme' " and " 'integrated system of procedures for enforcement,' "[16] the Court stated that ERISA's enforcement provision, § 502(a), was "essential to accomplish[ing] Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans."[17] As ERISA § 502(a)(1)(B) already provided a cause of action for a plan participant to recover wrongfully denied benefits,[18] the alleged injuries covered by the Texas statute were duplicative and, thus, preempted.[19]

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[14] *Hines v. Davidowitz,* 312 U.S. 52, 67, 61 S.Ct. 399, 85 L.Ed. 581 (1941); *Pac. Gas & Elec. Co.,* 461 U.S. at 203-04, 103 S.Ct. 1713.

[15] 542 U.S. 200, 209, 124 S.Ct. 2488, 159 L.Ed.2d 312; *see also Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 54-56, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987); *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 143-45, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990).

[16] *Davila,* 542 U.S. at 208, 124 S.Ct. 2488 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell,* 473 U.S. 134, 147, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985) (internal quotation marks and citation omitted)).

[17] *Davila,* 542 U.S. at 208, 124 S.Ct. 2488; 29 U.S.C. § 1132(a).

[18] ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) ("A civil action may be brought-(1) by a participant or beneficiary ... (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.").

[19] *Davila,* 542 U.S. at 214, 124 S.Ct. 2488. At the district court, Blue Cross also relied on the Third Circuit's decision in *Barber v. Unum Life Insurance Co. of Am.*, which considered a Pennsylvania statute providing

Blue Cross contends that *Davila* is controlling because the assignment statute provides a "separate vehicle" for asserting benefits claims, creating a remedy that "duplicates, supplements, or supplants" ERISA's exclusive enforcement scheme. According to Blue Cross, the assignment statute gives hospitals, to which benefits have been assigned in contravention of the plan's express terms, a state-law cause of action against the ERISA plan to collect the assigned benefits. Further, Blue Cross contends the statute creates a supplemental remedy, as it provides that any payment to the participant, in accordance with plan terms, does not release the plan from liability to the hospital. To Blue Cross, the statute authorizes double recovery against the ERISA plan.

[5] Louisiana's assignment statute is readily distinguishable from the Texas law providing a negligence cause of action for the denial of benefits. First, unlike the ***535** enforcement provisions at issue in *Davila,* ERISA is silent on the assignability of employee welfare benefits; it neither prohibits assignments nor mandates recognition of assignments. [20] The Texas statute at issue in *Davila* was

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punitive damages for the bad faith denial of insurance claims. 383 F.3d 134, 136 (3d Cir.2004). That court, relying on *Davila,* concluded that the statute created a conflict with ERISA's exclusive enforcement scheme. *Id.* at 141. For the same reasons *Davila* is not controlling, *Barber* is not persuasive. *See also Cicio v. John Does 1-8,* 385 F.3d 156 (2d Cir.2004) (finding a state law malpractice claim preempted by ERISA because it would provide consequential and punitive damages in connection with a benefits claim); *Land v. CIGNA Healthcare of Fla.,* 381 F.3d 1274 (11th Cir.2004) (state law medical malpractice claim preempted).

[20] *Hermann Hosp. v. MEBA Med. & Benefits Plan,* 845 F.2d 1286, 1289 (5th Cir.1988) ("*Hermann I*") ("ERISA contains no anti-assignment provision with regard to health care benefits of ERISA-governed medical plans, nor is there any language in the statute which even remotely suggests that such assignments are proscribed or ought in any way to be limited."); *cf.* ERISA § 206(d)(1), 29 U.S.C. § 1056(d)(1) (providing,

preempted, in large part, because of the specific enforcement provisions provided by Congress.[21] Second, the assignment statute does not create an additional means to enforce payment of benefits under an ERISA plan. The Texas statute at issue in *Davila,* in contrast, imposed a "duty" on any health maintenance organization "to exercise ordinary care when making health care treatment decisions" and imposed liability for any damages proximately caused by a failure to exercise ordinary care.[22] The assignment of benefits from the patient to the hospital results solely in the transfer of the cause of action provided by § 502(a) from the patient to the hospital. The assignee takes what the assignor had; no more, no less.[23] The assignment statute merely

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with certain exceptions, that "[e]ach pension plan shall provide that benefits provided under the plan may not be assigned or alienated").

[21] *Davila*, 542 U.S. at 208-09, 124 S.Ct. 2488. As the Court noted in *Pilot Life,*

> [T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Pilot Life Ins., 481 U.S. at 54, 107 S.Ct. 1549; *see also Russell,* 473 U.S. at 146, 105 S.Ct. 3085 ("The six carefully integrated civil enforcement provisions found in § 502(a) ... provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.").

[22] *See* Tex. Civ. Prac. & Rem.Code Ann. § 88.002(a) (Vernon 2004) ("A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care."). After *Davila,* the Texas legislature clarified that § 88.002(a) did not apply to employee benefit plans regulated by ERISA. *See id.* § 88.015.

[23] *Tango Transport v. Healthcare Fin. Servs.*, 322 F.3d 888, 894 (5th

passes the sole enforcement mechanism-ERISA § 502-from patient to hospital; it does not impose any additional obligation on the ERISA plan administrator, nor does it create additional or separate means of enforcement. [24]

In addition, Blue Cross argues that the assignment statute authorizes a "double recovery" of employee welfare benefits. According to Blue Cross, it must pay benefits to a patient, in conformance with the express terms of the plan, but that such payment will not discharge liability to a provider that has been assigned the patient's benefits claim. This argument is similarly without merit. Blue Cross's obligation to pay the provider only arises if ***536** Blue Cross has notice of the assignment.[25] If Blue Cross complies with the assignment, then it only pays one time; if Blue Cross ignores the assignment, then it risks paying a claim twice. Failure to follow the law cannot create preemption concerns. Should Blue Cross pay a patient after receiving notice that the patient assigned her benefits claim to a hospital, Blue Cross can seek recovery from the person improperly paid (here, the patient),[26] and Blue Cross recognizes the availability of this remedy in its plan terms, as it reserves the right to recover improper payments.

We conclude that Louisiana's assignment statute is not in conflict with the exclusive enforcement mechanism provided by ERISA. We now turn to Blue Cross's contention that the statute is preempted as a law that "relate[s] to" employee

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Cir.2003); *Hermann Hosp. v. MEBA Med. and Benefits Plan*, 959 F.2d 569, 572 (5th Cir.1992) ("*Hermann II*").

[24] *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002) (recognizing that "a state regulatory scheme that provides no new cause of action under state law and authorizes no new form of ultimate relief" is not preempted).

[25] *See* La.Rev.Stat. Ann. § 40:2010.

[26] *See Bombardier Aerospace Emp. Wel. Benef. Plan v. Ferrer, Poirot and Wansbrough*, 354 F.3d 348, 356-58 (5th Cir.2003).

benefit plans.

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[6] Congress expressly provides that ERISA "shall supersede any and all State laws insofar as they now or hereafter relate to" any employee benefit plan.[27] Our task is to determine whether the assignment statute "relate[s] to" employee benefit plans. The "unhelpful text" of ERISA's preemption provision neither directs, nor informs, our inquiry;[28] rather, we gain insight solely from the Supreme Court's application of the provision to particular state statutes.

The Supreme Court directs that a law "relates to" an employee benefit plan if "it has a connection with or reference to such a plan."[29] A state law "refers" to an ERISA plan if it acts "immediately and exclusively upon ERISA plans"[30] or if "the existence of an ERISA plan is essential to the law's operation."[31] A law does not refer to an

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[27] ERISA § 514(a), 29 U.S.C. § 1144(a).

[28] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995).

[29] *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983).

[30] *Cal. Div. of Labor Enforcement v. Dillingham Constr.*, 519 U.S. 316, 324-25, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997) (referencing *Mackey v. Lanier Collection Agency & Svc., Inc.*, 486 U.S. 825, 828-30, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988), in which the Court held that ERISA preempted a state statute that expressly prohibited garnishment of employee welfare plan benefits).

[31] *Dillingham*, 519 U.S. at 324-25, 117 S.Ct. 832 (referencing *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130, 113 S.Ct. 580, 121 L.Ed.2d 513 (1992), in which the Court held that ERISA preempted a state statute that applied only to employers who provided health insurance coverage, and *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990), in which the Court held that ERISA preempted a common-law cause of action premised on the existence of an ERISA plan).

ERISA plan if it applies neutrally to ERISA plans and other types of plans.[32] The "reference to" prong is inapplicable here, as the assignment statute operates without regard to the existence of ERISA plans and does not immediately and exclusively act on such plans: it applies to insurance companies, employee benefit trusts, self-insurance plans, and ***537** other entities that are obligated to reimburse individuals for the charges incurred for hospital services.[33] Thus, the assignment statute is preempted only if it has a "connection with" ERISA plans.

We discern no precise formula for calculating whether a state law has an impermissible connection with an employee benefit plan. The Supreme Court broadly instructs us to look at the objectives of ERISA and the nature and effect of the state law on ERISA plans.[34] In cases like this one, in which Blue Cross contends that federal law bars state action in a field of traditional state regulation,[35] we start with the assumption that "the historic police powers of the States were not to be superseded by [ERISA] unless that was the clear and manifest purpose of Congress."[36] Preemption will

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[32] *Dillingham,* 519 U.S. at 325-28, 117 S.Ct. 832 (refusing to hold that a state statute pertaining to approved apprenticeship programs "referred to" ERISA plans because not all such programs were ERISA plans); *see also Corporation Health Ins. v. Tx. Dep't of Ins.,* 215 F.3d 526, 535 (5th Cir.2000), *op. modified,* 314 F.3d 784 (5th Cir.2002).

[33] *See* La.Rev.Stat. Ann. § 40:2010; *cf. Mackey,* 486 U.S. at 829, 108 S.Ct. 2182 (holding that a Georgia garnishment statute that solely applied to ERISA employee benefit plans was preempted).

[34] *Dillingham,* 519 U.S. at 325, 117 S.Ct. 832 (quoting *Travelers,* 514 U.S. at 656, 115 S.Ct. 1671).

[35] *See, e.g., DeBuono v. NYSA-ILA Med. & Clinical Svcs.,* 520 U.S. 806, 814, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997) (noting that "the historic police powers of the State include the regulation of matters of health and safety" (citing *Hillsborough County v. Automated Med. Laboratories, Inc.,* 471 U.S. 707, 715, 105 S.Ct. 2371, 85 L.Ed.2d 714 (1985))).

[36] *Travelers,* 514 U.S. at 655, 115 S.Ct. 1671; *Dillingham,* 519 U.S. at 325, 117 S.Ct. 832; *Rice,* 331 U.S. at 230, 67 S.Ct. 1146.

not occur if a state law has only a "tenuous, remote, or peripheral" connection with covered employee benefit plans.[37]

Both parties agree that ERISA is silent on the assignability of employee welfare benefits. As is often the case, congressional silence whispers sweet nothings in the ears of both parties. Blue Cross contends that silence implies that Congress intended to leave the assignment of employee welfare benefits to the free negotiations of the contracting parties; the Hospitals, in contrast, contend that silence speaks and it says that Congress did not intend to preclude statutes mandating enforcement of assignments, especially when considered in light of the express prohibition on the assignment of pension benefits.[38] Congressional silence cannot dictate our conclusion in this case, but we consider what Congress did in order to determine what Congress intended to preclude the states from doing.

Likewise, both parties direct our attention to our prior precedent concerning assignment of benefits. We have held that an assignee has derivative standing to enforce claims under ERISA § 502, thus permitting assignments when not precluded by the plan terms.[39] We have also held that, absent a statute to the contrary, an anti-assignment provision

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[37] *Greater Wash. Bd. of Trade*, 506 U.S. at 130, 113 S.Ct. 580.

[38] *See* ERISA § 206(d)(1), 29 U.S.C. § 1056(d)(1); *cf. Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 829, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988) (concluding that a general state garnishment statute's application to employee welfare benefits was not preempted by ERISA because ERISA was silent about enforcement mechanisms for money judgments whereas ERISA explicitly prohibited assignment of pension benefits).

[39] *See Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289 & n. 13 (5th Cir.1988).

in a plan is permissible under ERISA.[40] None of this ***538** resolves the question in this case-namely, whether Louisiana's assignment statute is preempted under ERISA § 514 as a state law that "relate[s] to" employee welfare benefits.

Blue Cross relies primarily on the Supreme Court's decision in *Egelhoff v. Egelhoff*,[41] which concerned a Washington statute that revoked by operation of law the designation of a spouse as the beneficiary of all nonprobate assets, including ERISA plan benefits, upon dissolution of marriage.[42] The Court found fault with two aspects of the Washington statute. First, the statute bound ERISA plan administrators "to a particular choice of rules for determining beneficiary status."[43] To the Court, the statute forced administrators to pay benefits to beneficiaries chosen by state law, rather than those specified in the plan documents. This conflicted with ERISA's requirements that fiduciaries administer plans "in accordance with the documents and instruments governing the plan"[44] and that fiduciaries make payments to beneficiaries "designated by a participant or by the terms of [the] plan."[45]

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[40] *See LeTourneau Lifelike Orthotics & Prosthetics, Inc.*, 298 F.3d 348, 352 (5th Cir.2002) (holding that anti-assignment provisions are not *per se* invalid as applied to health care providers); *see also Physicians Multispecialty Group v. The Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1295-96 (11th Cir.2004); *City of Hope Nat'l Med. Ctr. v. HealthPlus, Inc.*, 156 F.3d 223, 229 (1st Cir.1998); *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1480-81 (9th Cir.1991).

[41] 532 U.S. 141, 121 S.Ct. 1322, 149 L.Ed.2d 264 (2001).

[42] *See* Wash. Rev.Code § 11.07.010(2)(a) (1994) ("If a marriage is dissolved or invalidated, a provision made prior to that event that relates to the payment or transfer at death of the decedent's interest in a nonprobate asset in favor of or granting an interest or power to the decedent's former spouse is revoked.").

[43] *Egelhoff*, 532 U.S. at 147, 121 S.Ct. 1322.

[44] *Id.* (citing ERISA § 402(b)(4), 29 U.S.C. § 1102(b)(4)).

[45] *Id.* (citing ERISA § 3(8), 29 U.S.C. § 1002(8)).

Second, the Court found the Washington statute interfered with one of the "primary" goals of ERISA: establishing a uniform administrative scheme with a set of standard procedures to guide processing of claims and disbursement of benefits.[46] The existence of the Washington statute required plan administrators to look beyond the plan documents to the effects of state law before making payments to beneficiaries. Exacerbated by various choice-of-law problems, the statute's burden on plan administrators was not militated by provisions protecting administrators from liability unless they had actual knowledge of the dissolution of marriage and permitting administrators to refuse payment until resolving who was a proper beneficiary.[47]

Blue Cross finds both faults in the assignment statute. First, Blue Cross contends *Egelhoff* is controlling because Louisiana's assignment statute binds ERISA plans to a set of rules that govern to whom benefits must be paid in contravention of the plan documents. We disagree. The Washington statute operated as a matter of law, invalidating a plan's designation of beneficiary upon dissolution of marriage. Louisiana's assignment statute, in contrast, requires an affirmative act by the plan participant; it enforces the free will of the plan participant, which is consistent with ERISA's choice of beneficiary. As recognized by the Court in *Egelhoff,* ERISA directs that administrators must pay beneficiaries who are "designated by a participant or by the terms of [the] plan."[48] The Washington statute imposed a third ***539** alternative,

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[46] *Id.; Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1, 9, 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987).

[47] *Egelhoff,* 532 U.S. at 148-50, 121 S.Ct. 1322.

[48] *Id.* at 147, 121 S.Ct. 1322 (citing ERISA § 3(8), 29 U.S.C. § 1002(8)).

requiring payment to beneficiaries designated "by operation of law." Louisiana's assignment statute, in contrast, is consistent with the express terms of ERISA-leaving the beneficiary determination to *either* the person designated by the participant or the person designated by the plan.

We also disagree with Blue Cross's contention that application of the assignment statute will impermissibly interfere with nationally uniform plan administration. To be sure, ERISA was enacted, in large measure, "to establish a uniform administrative scheme" with "a set of standard procedures to guide processing claims and disbursement of benefits."[49] However, a statute's impact on nationally uniform plan administration must be evaluated in light of the particular burden the statute imposes on plan administration. The greater the impact, the greater the burden. As the Court recognized in *Egelhoff,* "all state laws create some potential for lack of uniformity." [50]

Here, the burden on plan administrators is minimal, especially given that Louisiana requires all insurance claims to be submitted on a uniform claim form that includes space for indicating whether benefits have been assigned. [51]

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[49] *Fort Halifax Packing Co.,* 482 U.S. at 9, 107 S.Ct. 2211; *see also Davila,* 542 U.S. at 208, 124 S.Ct. 2488 ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans."); *Ingersoll-Rand,* 498 U.S. at 142-45, 111 S.Ct. 478; *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 64-66, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987).

[50] *Egelhoff,* 532 U.S. at 150, 121 S.Ct. 1322; *see also Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 365, 122 S.Ct. 2151, 153 L.Ed.2d 375 (recognizing that "it was beyond dispute" that a state statute that required all insured benefit plans "to submit to an extra layer of review for certain benefit denials" had a substantial effect on ERISA plans).

[51] *See* La.Rev.Stat. Ann. § 22:213(A)(14) ("Notwithstanding any other law to the contrary, including Paragraph (4) of this Subsection, all claims shall be processed in conformity with the uniform claim form issued by the [DOI].").

Further, the assignment statute will not create any additional paperwork for Blue Cross and, in fact, it may lesson Blue Cross's administrative responsibilities. With or without assignment, Blue Cross will pay benefits only one time, and payment is triggered upon submission of a claim form. To Blue Cross, it should not matter whether that claim form comes from the plan participant, as provided in the plan documents, or from the hospital, as assignee of the participant's benefits claim. Further, as pointed out by amicus curiae, most hospitals file claims with insurance companies electronically, which mitigates the administrative burden. The burden seems greater when many individuals [sic] plan participants must each individually file claims with Blue Cross, especially given the intricacies of coverages, deductibles, and retentions of most health care plans. By consolidating many different individual claims, hospitals can channel expertise in the benefits process. Tellingly, Blue Cross concedes that it must honor assignments made under non-ERISA plans, which suggests that it already has in place some administrative mechanism for complying with the statute. Taken together, the burden imposed by the assignment statute, especially given its consistency with ERISA § 3(8), is minimal, militating concerns over the statute's effect on nationally uniform plan administration.

We acknowledge that both the Eighth and Tenth Circuits have concluded that ERISA preempts similar assignment statutes.[52] After review of those decisions, as ***540** well as intervening Supreme Court precedent, we are convinced that Louisiana's assignment statute does not have the impermissible connection with ERISA plans.

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[52] See *Ar. Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341 (8th Cir.1991); *St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Ks., Inc.*, 49 F.3d 1460 (10th Cir.1995).

Both the Eighth and Tenth Circuits interpreted ERISA's silence on the assignability of benefits claims as leaving the issue to the free negotiation and agreement of the parties.[53] As we have already noted, congressional silence points in both directions: either leaving assignment of employee welfare benefits to the parties or leaving room for state regulation, should a state desire to intervene. In *Mackey v. Lanier Collection Agency & Service,* the Supreme Court interpreted congressional silence as to the garnishment of employee welfare benefits not to preempt application of a general garnishment statute to employee welfare benefits, especially in light of an express prohibition on the garnishment of employee pension benefits. [54] Likewise, ERISA specifically precludes assignment of pension plan benefits.[55] As such, "there is no ignoring the fact that, when Congress was adopting ERISA, it had before it a provision to bar the [assignment of ERISA plan benefits], and chose to impose that limitation only with respect to ERISA pension benefit plans, and *not* ERISA welfare benefit plans."[56]

Moreover, both the Eighth and Tenth Circuits decided the preemption question prior to the Supreme Court's rejection, starting in *Travelers,* of an "uncritical literalism" in the application of ERISA's "unhelpful text." [57] As we have

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[53] *St. Mary's Hosp.,* 947 F.2d at 1349 ("[I]f Congress intended that ERISA participants could negotiate plan provisions governing the right to assign welfare benefits, it is more likely that Congress would say nothing at all about welfare benefit assignment."); *St. Francis,* 49 F.3d at 1464 ("We interpret ERISA as leaving the assignability of benefits to the free negotiations and agreement of the contracting parties.").

[54] 486 U.S. 825, 836, 108 S.Ct. 2182, 100 L.Ed.2d 836.

[55] ERISA § 206(d)(1), 29 U.S.C. § 1056(d)(1).

[56] *Mackey,* 486 U.S. at 837, 108 S.Ct. 2182.

[57] 514 U.S. 645, 656, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995); *see also Cal. Div. Of Labor Enforcement v. Dillingham Constr.,* 519 U.S. 316, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997); *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund,* 520 U.S. 806, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997); *Boggs v. Boggs,* 520 U.S. 833, 117 S.Ct. 1754, 138 L.Ed.2d 45

previously noted, the Supreme Court has returned "to a traditional analysis of preemption, asking if a state regulation frustrated the federal interest in uniformity."[58] Neither the Eighth nor Tenth Circuits operated with the starting assumption that Congress did not intended [sic] to preempt state law in an area of traditional state regulation.[59]

Finally, both parties offer differing accounts of what is "best" in the public's interest. The Hospitals, with support ***541** from the State of Louisiana and amicus curiae AARP and the Louisiana Hospital Association, argue that the assignment statute facilitates delivery of medical treatment to patients, especially low-income patients. To Blue Cross, the assignment statute deprives Blue Cross of a significant carrot-the availability of direct payments. Although recognizing that consumers benefit when Blue Cross pays hospitals directly, Blue Cross uses the availability of direct payments as an important incentive for hospitals to join its provider networks, which requires reduced rates for medical care.

Neither policy choice is absurd, but the preemption inquiry is not resolved by or concerned with arguments of policy. We

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(1997) (applying traditional preemption analysis in concluding state testamentary laws were preempted as applied to an ERISA pension fund).

[58] *Corp. Health Ins., Inc. v. Tx. Dep't of Ins.*, 215 F.3d 526, 533 (5th Cir.2000), *op. mod. and reinstated*, 314 F.3d 784 (5th Cir.2002). This view is in accord with that of other circuits. *See Wright Elec. v. Mn. State Bd. of Elec.*, 322 F.3d 1025, 1029 (8th Cir.2003) (collecting cases).

[59] *St. Mary's Hosp.*, 947 F.2d at 1350 ("We reject St. Mary's argument that preemption is not appropriate because the assignment statute is an exercise of traditional state power .... Although the Supreme Court has not discussed the relevance of this factor, its failure to consider this criterion when deciding ERISA preemption cases is telling." (citing *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990), and *Mackey*, 486 U.S. 825, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988)); *St. Francis*, 49 F.3d at 1464 (relying largely on the Eighth Circuit's decision in *St. Mary's Hospital*)).

operate between two conflicting principles: On the one hand, Congress passed ERISA, a comprehensive statute with a "clearly expansive" preemption provision.[60] On the other hand, the Supreme Court requires our analysis to start with the assumption that ERISA was not intended to derogate the historic police powers of the states.[61] The second assumption does not eliminate the first, but we walk a fine line between permissible and impermissible state regulation in this context. As we conclude that Louisiana's assignment statute is not preempted by ERISA, we leave the public policy decision to Louisiana's legislative body. They have chosen assignment of benefit claims over inducing hospitals to enter into Blue Cross's provider networks. Nothing in ERISA requires us to alter that choice.

C

As we conclude that Louisiana's assignment statute is not preempted by ERISA, we need not consider whether the statute is saved from preemption as a law regulating insurance.[62]

III

Accordingly, the district court's judgment is AFFIRMED.
OWEN, Circuit Judge, concurring:

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[60] *See Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 324, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997) (collecting various descriptions of ERISA's preemption provision).

[61] *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-55, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995).

[62] ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) ("Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates, insurance, banking, or securities.").

I concur in the judgment. We need not resolve whether section 40:2010 of the Louisiana Revised Statutes "relates to" an employee benefit plan within the meaning of 29 U.S.C. § 1144(a)[1] and the Supreme Court's decisions interpreting and applying that provision. Section 40:2010 is saved from preemption under 29 U.S.C. § 1144(b)(2)(A) as a law that "regulates insurance."[2] Section 40:2010's application to the ERISA benefit plans at issue is accordingly not preempted.

***542** I

Louisiana Health Service & Indemnity Co., doing business as Blue Cross and Blue Shield of Louisiana, insures and administers employee benefit plans that are subject to ERISA. In providing and administering health care benefits, Blue Cross has contracted with hospitals, physicians and others, whom it calls Participating Providers, and agreed to provide direct payment for services rendered to plan beneficiaries. If a plan beneficiary obtains the services of a non-Participating Provider, Blue Cross will reimburse the plan beneficiary but will not make direct payment to the non-Participating Provider. The terms of the ERISA plans that

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[1] That section states:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975. 29 U.S.C. § 1144(a).

[2] *Id.* § 1144(b)(2)(A) ("Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.").

Blue Cross insures or administers are congruent with Blue Cross's method of doing business and provide that assignments by a plan beneficiary to providers other than Participating Providers will not be honored.

I agree with the panel majority that the ERISA plans Blue Cross insures or administers contravene section 40:2010 of the Louisiana Revised Statutes. Section 40:2010 requires insurers to pay benefits directly to a hospital when the insurer has notice that a beneficiary has assigned benefits to that hospital. Section 40:2010 provides:

Not later than ten business days after the date of discharge, each hospital in the state which is licensed by the Department of Health and Hospitals shall have available an itemized statement of billed services for individuals who have received the services from the hospital. The availability of the statement shall be made known to each individual who receives service from the hospital before the individual is discharged from the hospital, and a duplicate copy of the billed services statement shall be presented to each patient within the specified ten day period. No insurance company, employee benefit trust, self-insurance plan, or other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered by the hospital shall pay those benefits to the individual when the itemized statement submitted to such entity clearly indicates that the individual's rights to those benefits have been assigned to the hospital. When any insurance company, employee benefit trust, self-insurance plan, or other entity has notice of such assignment prior to such payment, any payment to the insured shall not release said entity from liability to the hospital to which the benefits have been assigned, nor shall such payment be a defense to any action by the hospital against that entity to collect the assigned benefits. However, an interim statement shall be

provided when requested by the patient or his authorized agent.[3]

Assuming, *arguendo,* that Blue Cross is correct in contending that the directives in this statute regarding assignments of benefits "relate to" an ERISA employee benefit plan, the Louisiana statute is saved from preemption by the saving clause in 29 U.S.C. § 1144(b)(2)(A). That clause says: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."[4] The ***543** Supreme Court has held that through this saving clause, state laws may indirectly regulate employee benefit plans that are insured.[5] The Court has explained, "an insurance company that insures a plan remains an insurer for purposes of state laws 'purporting to regulate insurance,' " and an "ERISA plan is consequently bound by state insurance regulations insofar as

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[3] La.Rev.Stat. Ann. § 40:2010 (2001).

[4] 29 U.S.C. § 1144(b)(2)(A). Subparagraph B, referenced in this subsection, is the so-called "deemer clause" and provides:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. *Id.* § 1144(b)(2)(B).

[5] *See FMC Corp. v. Holliday,* 498 U.S. 52, 61, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990) (holding "employee benefit plans that are insured are subject to indirect state insurance regulation"); *Metro. Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 747, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985) (recognizing "a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not").

they apply to the plan's insurer."[6] Accordingly, even though the insured employee benefit plans Blue Cross insures or administers[7] may provide that assignments will not be honored, those provisions must give way to state law to the extent ERISA's insurance saving clause applies.[8] It is unnecessary to resolve whether the "deemer" clause, contained in 29 U.S.C. § 1144(b)(2)(B), precludes the application of the ERISA saving clause to self-funded ERISA benefit plans that Blue Cross might administer but not insure because the State of Louisiana concedes that it has not attempted to enforce section 40:2010 with regard to self-funded ERISA plans and Blue Cross does not contend that it administers any self-funded plans to which the State of Louisiana has sought to apply section 40:2010.[9]

Blue Cross does contend, though, that La.Rev.Stat. Ann. § 40:2010 does not "regulate[ ] insurance" within the meaning of ERISA's insurance saving clause. The Supreme Court's decision in *Kentucky Association of Health Plans, Inc. v.*

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[6] *FMC Corp.*, 498 U.S. at 61, 111 S.Ct. 403 (quoting 29 U.S.C. § 1144(b)(2)(B)).

[7] *See Ky. Ass'n of Health Plans, Inc. v. Miller,* 538 U.S. 329, 336 n. 1, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003) (stating that administration by noninsuring HMO's of even a self-insured plan "suffices to bring them within the activity of insurance for purposes of § 1144(b)(2)(A)").

[8] *See UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358, 375-76, 119 S.Ct. 1380, 143 L.Ed.2d 462 (1999) (rejecting the argument that an ERISA plan's terms always control, observing "insurers could displace any state regulation simply by inserting a contrary term in plan documents" which "would virtually 'rea[d] the saving clause out of ERISA' " (quoting *Metro. Life,* 471 U.S. at 741, 105 S.Ct. 2380)).

[9] *See generally Ky. Ass'n,* 538 U.S. at 336 n. 1, 123 S.Ct. 1471 (discussing the "deemer clause" and the reach of the saving clause when an insurance company or HMO acts only as an administrator of a self-insured ERISA plan); *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 372 n. 6, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002) (discussing the possibility that an HMO may provide only administrative services for a self-funded plan and stating that a state law "would not be 'saved' as an insurance law to the extent it applied to self-funded plans").

Miller[10] provides considerable guidance in resolving this question. The Court announced it was "mak[ing] a clean break from the [three] McCarran-Ferguson factors" it had referenced in prior opinions and held "that for a state law to be deemed a 'law ... which regulates insurance' under § 1144(b)(2)(A), it must satisfy two requirements."[11] Those are 1) "the state law must be specifically directed toward entities engaged in insurance" and 2) "the state law must substantially affect the risk ***544** pooling arrangement between the insurer and the insured."[12]

With regard to the first requirement, *Kentucky Association* explained that "laws of general application that have some bearing on insurers do not qualify" as a state law " 'specifically directed toward' the insurance industry,"[13] and "not all state laws 'specifically directed toward' the insurance industry will be covered by § 1144(b)(2)(A)."[14] "[I]nsurers must be regulated 'with respect to their insurance practices.' "[15]

At issue in *Kentucky Association* was a state statute that prohibited health insurers from discriminating against any provider located within the geographic coverage area of a health benefit plan and willing to meet the terms and conditions for participation established by that insurer and a corollary statute that directed that any chiropractor who agreed to the terms, conditions and rates of a health care benefit plan must be permitted to serve as a participating

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[10] 538 U.S. 329, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003).
[11] *Id.* at 341-42, 123 S.Ct. 1471.
[12] *Id.* at 342, 123 S.Ct. 1471.
[13] *Id.* at 334, 123 S.Ct. 1471 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987)).
[14] Id.
[15] *Id.* (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 366, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002)).

primary chiropractic provider.[16] The Supreme Court held that the ERISA saving clause saved these "any-willing-provider" statutes from preemption. The Court reasoned that the statutes " 'regulate[d]' insurance by imposing conditions on the right to engage in the business of insurance." [17]

With regard to the second requirement for application of the insurance saving clause, the Court concluded that the statutes at issue in *Kentucky Association* "substantially affect[ed] the risk pooling arrangement between [the] insurer and [the] insured" because "[b]y expanding the number of providers from whom an insured may receive health services, [any-willing-provider] laws alter the scope of permissible bargains between insurers and insureds."[18] The Court likened the any-willing-provider laws' impact to that of "mandated-benefit laws [it] upheld in *Metropolitan Life,* the notice-prejudice rule [it] sustained in *UNUM,* and the independent-review provisions [it] approved in *Rush Prudential.*"[19]

The Louisiana statute before us is directed toward entities that engage in insurance-"[any] insurance company, employee benefit trust, self-insurance plan, or other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered by the hospital."[20] The statute's inclusion of "self-insured plans" does not preclude it from qualifying as a law that

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[16] *Id.* at 331-32, 123 S.Ct. 1471.
[17] *Id.* at 338, 123 S.Ct. 1471.
[18] *Id.* at 338-39, 123 S.Ct. 1471.
[19] *Id.* at 339, 123 S.Ct. 1471 (referring to *Metro. Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), *UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358, 119 S.Ct. 1380, 143 L.Ed.2d 462 (1999), and *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002)).
[20] La.Rev.Stat. Ann. § 40:2010.

"regulates insurance."[21] Even benefit plans that are self-funded "engage in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan," and in the absence*545 of § 1144(b)(2)(B) (the "deemer clause"), self-funded plans could be regulated by states under the insurance saving clause.[22] The Supreme Court has said, "We do not think [a state law's] application to self-insured non-ERISA plans forfeits its status as a 'law ... which regulates insurance' under 29 U.S.C. § 1144(b)(2)(A)."[23] Likewise, nothing in the text of La.Rev.Stat. Ann. § 40:2010 regarding assignments indicates that the term "other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered" means anything other than an entity that is engaging is some sort of risk pool arrangement to provide benefits.

The fact that the Louisiana law requiring insurers to honor assignments of benefits to hospitals appears in a statute that also requires hospitals to provide an itemized bill to patients within ten days is of no moment. The provisions that are directed at insurance companies are not directed at hospitals, and mere inclusion of those provisions with other separable regulations does not preclude the provisions aimed at insurers from qualifying as laws "regulat[ing] insurance" under ERISA's insurance saving clause. Nor is it of any

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[21] *See Ky. Ass'n,* 538 U.S. at 336 n. 1, 123 S.Ct. 1471 (discussing the interplay between the insurance saving clause in 29 U.S.C. § 1144(b)(2)(A) and the deemer clause in 29 U.S.C. § 1144(b)(2)(B)).

[22] Id.

[23] *Id.*; see also *Rush Prudential*, 536 U.S. at 372, 122 S.Ct. 2151 (observing that because the "deemer clause" provides an exception to the saving clause, a state law would not be saved under 29 U.S.C. § 1144(2)(b)(A) to the extent is applied to self-funded plans, but nevertheless, "there is no reason to think Congress would have meant such minimal application to noninsurers to remove a state law entirely from the category of insurance regulation").

significance that section 40:2010 is not within Louisiana's insurance code. The State of Louisiana has, through section 40:2010, directly regulated insurance by imposing conditions on the right to engage in the business of insurance in that State.[24]

The Louisiana statute before us satisfies the second requirement identified in *Kentucky Association* as well. Section 40:2010 substantially affects the risk pooling arrangement between the insurer and the insured in much the same way as the state law at issue in *Kentucky Association.* With regard to the any-willing-provider statutes at issue in *Kentucky Association*, the Supreme Court held that those statutes altered the scope of permissible bargains between insurers and insured and observed that Kentucky insureds could "[n]o longer ... seek insurance from a closed network of health-care providers in exchange for a lower premium."[25] Section 40:2010 similarly alters the scope of permissible bargains between insurers and insureds by prohibiting anti-assignment agreements. There is evidence in the record before us that some Louisiana hospitals who were not Participating Providers refused to accept Blue Cross beneficiaries as patients because Blue Cross would not honor patients' assignments of benefits, and Blue Cross would not pay non-Participating Providers directly. Section 40:2010 expands insureds' access to hospitals by removing this obstacle to treatment. Blue Cross must treat all hospitals equally with regard to assignments of benefits. Section 40:2010 also has the effect of requiring insurers like Blue

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[24] *See Ky. Ass'n,* 538 U.S. at 337-38, 123 S.Ct. 1471 (concluding that the any-willing-provider statute at issue regulated insurance and likening the statute to a state law requiring all licensed attorneys to participate in ten hours of continuing legal education, which, the Court said, would be a statute regulating the practice of law).

[25] *Id.* at 339, 123 S.Ct. 1471.

Cross to make allowance for instances in which they erroneously pay a beneficiary directly because payment to the beneficiary is not a defense to the ***546** insurer's obligation to pay the provider.[26] Although Blue Cross might seek to recover an erroneous payment from a beneficiary, some beneficiaries will not have the means, or will refuse, to repay. The unrecoverable costs associated with pursuing beneficiaries paid in error must additionally be taken into account. These considerations have the effect of increasing premiums and spreading the risk of erroneous payments among policyholders.

Section 40:2010 of the Louisiana Revised Statutes is also similar to the statute at issue in *FMC Corp. v. Holliday,* which prohibited insurers from exercising subrogation rights against an insured's tort recovery.[27] The Supreme Court concluded that the anti-subrogation statute would be saved from preemption to the extent that it applied to insured ERISA employee benefit plans, but the statute was preempted to the extent it applied to self-insured plans.[28]

I would hold that ERISA's insurance saving clause applies to La.Rev.Stat. Ann. § 40:2010. The only remaining question is whether section 40:2010 conflicts with ERISA's civil enforcement scheme.

II

Blue Cross contends that section 40:2010 creates a remedy in addition to those set forth in ERISA. That remedy, Blue

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[26] *See* La.Rev.Stat. Ann. § 40:2010 (2001).

[27] 498 U.S. 52, 55 n. 1, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990).

[28] *Id.* at 61, 111 S.Ct. 403 (holding that the state statute "returns the matter of subrogation to state law ... [u]nless the statute is excluded from the reach of the saving clause by virtue of the deemer clause").

Cross contends, is the right to obtain a "double payment" in instances in which Blue Cross has notice of an assignment and pays the beneficiary instead of the hospital to whom the benefits have been assigned. The Supreme Court held in *Aetna Health Inc. v. Davila* that "even a state law that can arguably be characterized as 'regulating insurance' will be preempted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." [29]

ERISA's remedial scheme is set forth in 29 U.S.C. § 1132. That section authorizes a participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."[30] This section "clearly contemplates" that a money judgment may be obtained against benefit plans.[31]

Nothing in ERISA prevents a participant or beneficiary from assigning his or her rights to welfare benefits, which include health care benefits. Notably, ERISA affirmatively prohibits assignment of pension benefits.[32] This distinction led the Supreme Court to conclude that "Congress' decision to remain silent concerning the attachment or garnishment of ERISA welfare plan benefits 'acknowledged and accepted

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[29] 542 U.S. 200, 217-18, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004).

[30] 29 U.S.C. § 1132(a)(1)(B).

[31] *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 832-33 & n. 7, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988).

[32] 29 U.S.C. § 1056(d)(1) ("Each pension plan shall provide that benefits provided under the plan may not be assigned or alienated."); *see also Mackey*, 486 U.S. at 836, 108 S.Ct. 2182 (discussing anti-alienation provisions in 29 U.S.C. § 1056(d)(1) and stating, "Congress did not enact any similar provision applicable to ERISA *welfare* benefit plans").

the practice, rather than prohibiting it.' "[33] This Circuit has held that assignees*547 of welfare plan benefits have standing to enforce plan benefits under ERISA.[34]

An assignment of a plan beneficiary's right to receive welfare benefits does nothing more than transfer the right to be paid to the assignee. It does not create new rights outside of ERISA. Blue Cross argues that barring payment to a beneficiary as a defense and requiring payment to an assignee even if payment has been made to the beneficiary creates a new right outside of ERISA's remedial scheme. This contention has no merit. Suppose a plan administrator paid benefits to a former spouse rather than the current spouse of a participant. That mistake would not relieve the plan administrator of its obligation to pay the correct person. The Louisiana statute does not enlarge the rights, causes of action, or remedies of beneficiaries or their assignees. Section 40:2010 simply directs to whom payment must be made once there has been a valid assignment and the plan has received notice of that assignment.

* * * * *

For the foregoing reasons, I concur in the judgment.

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Louisiana Health Service & Indem. Co. v. Rapides Healthcare System,
461 F.3d 529, 38 Employee Benefits Cas. 1897

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[33] *Mackey*, 486 U.S. at 837-38, 108 S.Ct. 2182 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 516, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981)).

[34] *Tango Transp. v. Healthcare Fin. Servs. LLC*, 322 F.3d 888, 892 (5th Cir.2003); *see also Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289-90 (5th Cir.1988).

APPENDIX B
RULING AND JUDGMENT OF
THE UNITED STATES DISTRICT COURT,
MIDDLE DISTRICT OF LOUISIANA
OCTOBER 12, 2004

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

LOUISIANA HEALTH SERVICE
& INDEMNITY COMPANY d/b/a
BLUE CROSS AND BLUE SHIELD
OF LOUISIANA

CIVIL ACTION

VERSUS

NO. 00-694-D

RAPIDES HEALTHCARE SYSTEM
and STATE OF LOUISIANA, EX REL
RICHARD P. IEYOUB, ATTORNEY
GENERAL FOR THE STATE OF
LOUISIANA **JUDGE BRADY**

RULING ON MOTIONS FOR SUMMARY JUDGMENT

This matter is before the court on a motion for summary judgment (doc. 266) filed by the plaintiff, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("Blue Cross").

Also before the court are motions for summary judgment filed by defendant, Rapides Healthcare System ("Rapides"), and intervenor, Dauterive Hospital ("Dauterive") (doc. 263), and by defendant State of Louisiana (doc. 260). Defendants' motions are opposed (doc. 280) and (doc. 282).

Subject matter jurisdiction is based on federal question pursuant to 28 U.S.C. §1331 because the interpretation of the Employee Retirement Income Security Act, 29 U.S.C. §1101, [sic] et seq. ("ERISA") is necessary for resolution of the dispute.

BACKGROUND

The court clearly documented the factual background of this lawsuit in its prior ruling (doc. 102) dated April 15, 2002.[1] There, this court denied Blue Cross's first motion for summary judgment (doc. 50) holding ERISA does not preempt the Louisiana Assignment Statute, La. R.S. 40:2010, as applied to employee benefit plans insured or administered by Blue Cross.

Blue Cross filed the instant motion for summary judgment (doc. 266) again alleging ERISA preempts the provisions of La. R.S. 40:2010 as applied to fully insured employee benefit plans insured or administered by Blue Cross. Blue Cross is seeking to have this court vacate its prior decision and enter judgment in its favor, declaring that ERISA preempts La. R.S. 40:2010 to the extent its enforcement is sought with respect to ERISA plans. Conversely, Defendants argue they are entitled to summary judgment in accordance with the court's ruling on April 15, 2002.

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[1] *See Louisiana Health Serv. & Indem. Co. v. Rapides Healthcare System*, 213 F. Supp. 2d 650 (M.D. La. 2002).

SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate when the pleadings, answers to interrogatories, admissions, and affidavits on file indicate that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). Although this court considers the evidence in the light most favorable to the non-movant, the non-movant may not merely rest on allegations set forth in the pleadings. Instead, the non-movant must show that there is a genuine issue for trial. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49 (1986). If, once the non-movant has been given the opportunity to raise a genuine factual issue, no reasonable juror could find for the non-movant, summary judgment will be granted. *See Celotex Corp.*, 477 U.S. at 322; *see also* Fed. Rule Civ. P. 56(c).

ANALYSIS

Blue Cross argues the recent case of *Barber v. UNUM Life Ins. Co. of America*, _____ F.3d _____, 2004 WL 1964500 (3rd Cir. September 7, 2004) is supportive of its argument that ERISA preempts the Louisiana Assignment Statute. The court does not agree with Blue Cross's application of *Barber* to the facts in the present lawsuit.

In *Barber*, the issue was whether ERISA preempted Pennsylvania's bad faith statute for insurance claims. *Id.* at *1. The state statute at issue in *Barber* permitted the plaintiff to seek punitive damages from the defendant for allegedly denying disability benefits in bad faith.

ERISA's exclusive civil enforcement provision permits an ERISA-plan participant to recover benefits, to

obtain a declaratory judgment that he is entitled to benefits, and to enjoin an improper refusal to pay. 29 U.S.C. § 1132(a). Therefore, the Pennsylvania statute permitted a form of recovery (i.e. punitive damages) which was not included in 29 U.S.C. § 1132(a). The Third Circuit found a state statute is preempted by ERISA if it provides a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA. *Id.* at *4. Thus, the court held the Pennsylvania statute was subject to conflict preemption.

However, the Louisiana Assignment Statute is different than the Pennsylvania statute in *Barber*. Specifically, ERISA is silent on the issue of assignability of benefits in insurance plans and the Louisiana statute does not alter an existing ERISA provision. As noted in this court's previous ruling,[2] the Fifth Circuit has specifically found that ERISA permits assignments of health care benefits.[3] Therefore, the court is unpersuaded that the *Barber* decision is applicable in the instant lawsuit. [4]

In accordance with the court's previous ruling,[5] and the aforementioned reasoning, the court finds that the

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[2] *Id.*

[3] *See Hermann v. Hosp. v. MEBA Medical Benefit Plan*, 845 F.2d 1286 (5th Cir. 1988).

[4] Blue Cross accurately states the *Barber* court relied in part on the analysis set forth in *Aetna Health, Inc. v. Davila*, ____ S. Ct. ___, 2004 WL1373230 (June 21, 2004). The state law at issue in *Aetna* permitted claims for failure to exercise ordinary care in the handling of coverage decisions. Thus, the state law conflicted with the notion that individuals who allege they have been denied benefits are restricted to the civil enforcement provisions of ERISA. 29 U.S.C. § 1132(a)(1)(B). The Louisiana Assignment statute is distinguishable from the state law in *Aetna* because the Louisiana law does not alter any existing ERISA provisions.

[5] *See Louisiana Health Serv.*, 213 F. Supp. 2d 650 (M.D. La. 2002).

Louisiana Assignment Statute, La. R.S. 40:2010, is not conflict preempted by ERISA and finds the defendants are entitled to summary judgment.

Accordingly, the motion for summary judgment (doc. 266) filed by the plaintiff, Blue Cross, is hereby DENIED.

Furthermore, the motions for summary judgment (doc. 263) and (doc. 260) filed by defendants, Rapides and the State of Louisiana, are hereby GRANTED.

Baton Rouge, Louisiana, October 12th, 2004.

s/James J. Brady
JAMES J. BRADY, DISTRICT JUDGE
MIDDLE DISTRICT OF LOUISIANA

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

LOUISIANA HEALTH SERVICE
& INDEMNITY COMPANY d/b/a
BLUE CROSS AND BLUE SHIELD
OF LOUISIANA

CIVIL ACTION

VERSUS

NO. 00-694-D

RAPIDES HEALTHCARE SYSTEM
and STATE OF LOUISIANA, EX REL.
RICHARD P. IEYOUB, ATTORNEY
GENERAL FOR THE STATE OF
LOUISIANA **JUDGE BRADY**

JUDGMENT

For written reasons assigned,

IT IS ORDERED, ADJUDGED AND DECREED that judgment be entered in favor of the defendants, Rapides Healthcare System and the State of Louisiana, and intervenor, Dauterive Hospital Corp. and against the plaintiff, Blue Cross, and this action is hereby dismissed.

Baton Rouge, Louisiana, October 12th, 2004.

s/James J. Brady
JAMES J. BRADY, DISTRICT JUDGE
MIDDLE DISTRICT OF LOUISIANA

APPENDIX C
DECISION OF
THE UNITED STATES DISTRICT COURT,
MIDDLE DISTRICT OF LOUISIANA
APRIL 15, 2002

United States District Court,
M.D. Louisiana.

LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY d/b/a Blue Cross and Blue Shield of Louisiana,

v.

RAPIDES HEALTHCARE SYSTEM and State of Louisiana, ex rel. Richard P. Ieyoub, Attorney General for the State of Louisiana.

No. Civ.A.00-694-D.

213 F.Supp.2d 650

April 15, 2002.

651 *RULING ON MOTION FOR SUMMARY JUDGMENT

BRADY, District Judge.

This matter is before the court on a motion for summary judgment (doc. 50) filed by the plaintiff, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("Blue Cross"). The motion is opposed, and *amicus curiae* briefs have been filed on behalf of the defendants by the Louisiana Department of Insurance and the Louisiana Hospital Association. Subject matter jurisdiction is based on federal question pursuant to 28 U.S.C. § 1331 because the interpretation of the Employee

Retirement Income Security Act, 29 U.S.C. § 1101, [sic] et seq. ("ERISA") is necessary for resolution of the dispute.

Blue Cross filed this lawsuit seeking a declaration that ERISA preempts the provisions of La. R.S. 40:2010 (the "Louisiana Assignment Statute") as applied to employee benefit plans governed by ERISA and insured or administered by Blue Cross. The lawsuit was filed because the Louisiana Department of Insurance, acting upon complaints submitted by defendant Rapides Healthcare System ("Rapides"), had issued findings that health insurance policies issued or administered by Blue Cross violated various state laws, including the Louisiana Assignment Statute. Blue Cross seeks a declaratory judgment based on ERISA's broad preemption provision in order to prevent actions being brought against it for violation of the Louisiana statute.

FACTUAL BACKGROUND

Blue Cross underwrites, provides, and administers various forms of health care service plans for individual and group members who become subscribers. A portion of the health benefit plans that Blue Cross insures and administers are employee welfare benefit plans governed by ERISA. ERISA defines an "employee welfare benefit plan" as one "established or maintained by an employer or by an employee organization" for the purpose of providing employees with "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death," whether these benefits are provided "through the purchase of insurance or otherwise." *See* 29 U.S.C. § 1002(1).

As part of its plan administration, Blue Cross enters into individual and group contracts to provide health benefits to

subscribers and also enters into contracts with various health care providers for the provision of health care services to its subscribers. When Blue Cross has a contract with a health care provider that includes a provision allowing for direct payment to the provider, then Blue Cross will make payment directly to that provider. However, Blue Cross' insurance contracts all provide that, in the absence of such an agreement with the provider for direct payment, Blue Cross will pay benefits only to the subscriber (the patient), and it will not recognize the patient's attempted assignment of benefits to the provider. Therefore, Blue Cross will pay a hospital or provider directly only if such hospital or provider has an agreement with Blue Cross for direct payment. Otherwise, Blue Cross will only pay benefits to the patient, and then it is the patient's responsibility to make sure that the provider is paid.

Blue Cross' refusal to recognize certain assignments of benefits by patients is included as a provision in its contracts for health benefit plans, including its ERISA plans. Although ERISA establishes uniform procedural standards concerning reporting, disclosure, and fiduciary responsibility of plan administrators, it does not regulate the substantive content and terms of employee benefit plans. *See* *652 *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985). ERISA requires that an employee benefit plan be administered "in accordance with the documents and instruments governing the plan." See 29 U.S.C. § 1104(a)(1)(D). Therefore, Blue Cross argues that, in order to comply with ERISA, it must act in accordance with its ERISA plan provisions and refuse to honor assignments of benefits to providers that do not have a contract with Blue Cross.

However, Blue Cross' refusal to honor assignments is in direct conflict with the Louisiana Assignment Statute, La.

R.S. 40:2010, which requires Blue Cross and other insurers to honor all patients' assignments of benefits, even if the benefits are assigned to a provider that does not have a contract with Blue Cross providing for direct payment. Section 2010, entitled "Itemized statement of billed services by hospitals," appears within Title 40 of the Louisiana Revised Statutes, "Public Health and Safety," Chapter 11, "State Department of Hospitals," Part I, "Organization and Powers," and provides in its entirety:

> Not later than ten business days after the date of discharge, each hospital in the state which is licensed by the Department of Health and Hospitals shall have available an itemized statement of billed services for individuals who have received the services from the hospital. The availability of the statement shall be made known to each individual who receives service from the hospital before the individual is discharged from the hospital, and a duplicate copy of the billed services statement shall be presented to each patient within the specified ten day period. *No insurance company, employee benefit trust, self-insurance plan, or other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered by the hospital shall pay those benefits to the individual when the itemized statement submitted to such entity clearly indicates that the individual's rights to those benefits have been assigned to the hospital. When any insurance company, employee benefit trust, self-insurance plan, or other entity has notice of such assignment prior to such payment, any payment to the insured shall not release said entity from liability to the hospital to which the benefits have been assigned, nor shall such payment be a defense to any action by the hospital against that entity to collect the assigned benefits.*
>
> However, an interim statement shall be provided when

requested by the patient or his authorized agent. (emphasis added).

The italicized language is the focus of this lawsuit. Blue Cross argues that it cannot comply with both ERISA and La. R.S. 40:2010, and therefore, it asks this court to find that ERISA preempts the provisions of La. R.S. 40:2010 with respect to ERISA plans insured or administered by Blue Cross.

However, the State of Louisiana and Rapides (collectively "the defendants") argue that Blue Cross should not be permitted to violate Louisiana insurance law simply by "uttering the phrase ERISA preemption." They argue that the assignment of insurance benefits has long been a custom and tradition in the insurance industry, respected by insurance companies, protected by the Commissioner of Insurance, and mandated by state law. In fact, Blue Cross honored assignments of insurance benefits up until a little over a year ago. The defendants argue that Blue Cross is now refusing to honor assignments in an effort to punish its insured members who desire the freedom to select their own health care providers, rather than using only health care providers that have a contract with Blue Cross. The *653 defendants assert that ERISA does not preempt the Louisiana Assignment Statute because the Assignment Statute promotes the goals and purpose of ERISA and falls within the scope of state law which Congress never intended ERISA to preempt.

SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate when the pleadings, answers to interrogatories, admissions, and affidavits on file indicate that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of

law. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). Although this court considers the evidence in the light most favorable to the non-movant, the non-movant may not merely rest on allegations set forth in the pleadings. Instead, the non-movant must show that there is a genuine issue for trial. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). If, once the non-movant has been given the opportunity to raise a genuine factual issue, no reasonable juror could find for the non-movant, summary judgment will be granted. *See Celotex Corp.*, 477 U.S. at 322, 106 S.Ct. 2548; *see also* Fed. Rule Civ. P. 56(c).

ANALYSIS

[1] ERISA contains a broad preemption provision declaring that the federal statute "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. *See* 29 U.S.C. § 1144(a). Courts have interpreted this preemption clause expansively, observing that it was intended to displace all state laws that fall within its sphere and that its language was designed "to establish ... plan regulation as exclusively a federal concern." *CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana, ex rel. Ieyoub*, 82 F.3d 642, 646 (5th Cir.1996) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138, 111 S.Ct. 478, 482, 112 L.Ed.2d 474 (1990)). The phrase "relate to" has been given a commonsense meaning, and a state law "relates to" an employee benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); *Metropolitan Life*, 471 U.S. at 739, 105 S.Ct. 2380. It has repeatedly been held that ERISA preempts state laws that mandate employee benefit structures or their administration. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*

Ins. Co., 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995); *see also CIGNA Healthplan*, 82 F.3d at 647.

For example, the Fifth Circuit has held that ERISA preempts "any willing provider" statutes, which are statutes mandating that no licensed health care provider who agrees to the terms and conditions of a preferred provider contract shall be denied the right to become a preferred provider. In *CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana, ex rel. Ieyoub*, the Fifth Circuit found that Louisiana's "any willing provider" statute "related to" an ERISA plan because it specifically referred to entities that constituted ERISA-qualified plans and because it mandated the structures of employee benefit plans. *See CIGNA Healthplan*, 82 F.3d at 647-648. ERISA plans that chose to offer coverage by preferred provider organizations (PPOs) were limited by the Louisiana statute to using PPOs of a certain structure, i.e., a structure that included every willing, licensed provider. *Id.* at 648. The court found that the statute mandated that certain benefits available to ERISA plans be constructed in a particular manner, and therefore, the statute delineated the very structure of ERISA plans and impermissibly *654 bound plan administrators to a particular structure. *Id.* at 649.

Blue Cross argues that the Louisiana Assignment Statute attempts to bind it to a particular choice of rules as to how to pay health care benefits. Blue Cross claims that the Assignment Statute commands it to pay benefits in accordance with state law, rather than "in accordance with the documents and instruments governing the plan." Therefore, according to Blue Cross, there is an impermissible conflict between the state law and ERISA, and the state law must be preempted.

Although the Supreme Court has interpreted the language of

ERISA's preemption clause broadly, it has recognized in more recent cases that "the term 'relate to' cannot be taken 'to extend to the furthest stretch of its indeterminacy,' or else 'for all practical purposes preemption would never run its course.' " *Egelhoff v. Egelhoff, ex rel. Breiner*, 532 U.S. 141, 121 S.Ct. 1322, 149 L.Ed.2d 264 (2001); *Travelers*, 514 U.S. at 655, 115 S.Ct. 1671. The Court has found that some state laws may affect employee benefit plans in too tenuous, remote, or peripheral a manner to justify a finding that the law "relates to" the plan. *See CIGNA Healthplan*, 82 F.3d at 647; *see also Shaw*, 463 U.S. at 100, 103 S.Ct. 2890. The defendants argue that, in a trilogy of recent cases,[1] the Supreme Court has begun to move away from a broad reading of ERISA's preemption clause and toward a more traditional analysis of preemption.

For example, in the first of the three cases, a unanimous Supreme Court held that ERISA does not preempt state laws that have only an indirect economic effect on the relative costs of various health insurance packages available to ERISA-qualified plans. *See Travelers*, 514 U.S. at 668, 115 S.Ct. 1671. This is because an indirect economic influence does not bind plan administrators to any particular choice, and therefore, it does not function as a regulation of an ERISA plan itself. *Id.* at 659, 115 S.Ct. 1671.

The defendants argue that, with these three cases, the Supreme Court has begun to narrow the broad scope of ERISA preemption. They point out that in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*

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[1] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995); *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A.*, Inc., 519 U.S. 316, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997); *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997).

Ins. Co., the Supreme Court noted that it never assumes lightly that Congress has derogated state regulation, but instead begins with the presumption that Congress does not intend to supplant state law. *Id.* at 654, 115 S.Ct. 1671. The Court further stated that, in areas of traditional state regulation, it works on the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.* at 654, 115 S.Ct. 1671. The Court also recognized that, in determining whether a state law has a forbidden connection with ERISA plans, it is necessary to go beyond the unhelpful text of the preemption clause and look instead to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Egelhoff*, 532 U.S. at 147, 121 S.Ct. 1322; *Travelers*, 514 U.S. at 656, 115 S.Ct. 1671.

[2][3] The defendants argue that, instead of applying an all encompassing and *655 unrestricted rule of preemption, courts should consider the intent and purpose of ERISA and the specific facts of the case to determine whether a state law relates to an ERISA plan in some way and whether it should be deemed preempted because of an impermissible interference with the scheme of the ERISA statute. This court agrees with the defendants. One of Congress' goals in enacting ERISA was to enhance the health and welfare benefits of employees, and the Louisiana Assignment Statute should not be preempted because it does not interfere with this goal but, in fact, facilitates it. The Fifth Circuit has specifically recognized that an assignment of benefits to a health care provider facilitates rather than hampers the employee's receipt of health benefits. *See Hermann Hosp. v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir.1988). First of all, it keeps the employee from having to pay health care costs up front out of his own pocket.

Furthermore, health care providers are better equipped and financed to pursue an action for the payment of benefits. The honoring of benefit assignments to health care providers promotes efficiency in plan administration by streamlining the claims process and removing the patients from the payment process.

Not only does the Louisiana Assignment Statute facilitate and promote the goals of ERISA, it also constitutes a general health care regulation and is within the scope of state law that Congress did not intend ERISA to preempt. The Supreme Court has stated that general health care regulation has historically been a matter of local concern and that there is nothing in the language of ERISA to indicate that Congress intended to displace such general health care regulation. *See Travelers*, 514 U.S. at 661, 115 S.Ct. 1671. In fact, ERISA is completely silent on the issue of the assignability of benefits in insurance plans. ERISA specifically sets forth a prohibition against the assignment of employee pension benefits, but Congress chose not to include a parallel bar against the assignability of health care benefits. Congress' silence on the issue of the assignability of health care benefits gives rise to an inference that Congress intended to treat such benefits differently, and that Congress does not intend to enact a policy precluding their assignability. *See Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 836-37, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988); *see also Hermann Hosp.*, 845 F.2d at 1289.

Based on Congress' decision to remain silent on the issue, the Fifth Circuit has specifically found that ERISA permits assignments of health care benefits. *Hermann Hosp.*, 845 F.2d at 1289. Therefore, there is no conflict between ERISA and the Louisiana Assignment Statute. ERISA's silence on the issue of the assignability of health care benefits indicates

that Congress intended to allow the states to make their own decisions regarding assignability.

Blue Cross points out that other circuits have refused to interpret ERISA's silence on the issue of assignability of health care benefits as an invitation to the states to adopt their own rules pertaining to assignability. *City of Hope National Medical Center v. Healthplus, Inc.*, 156 F.3d 223, 229 (1st Cir.1998); *St. Francis Regional Medical Center v. Blue Cross & Blue Shield of Kansas*, 49 F.3d 1460, 1464 (10th Cir.1995). Instead, they interpret ERISA's silence as leaving the assignability of benefits to the free negotiations and agreement of the contracting parties. However, this court does not subscribe to the reasoning espoused by those circuits. The assignability of health care benefits has historically been a matter of local concern, and this court finds that Congress did not intend for ERISA to preempt state laws concerning assignability. Congress' *656 silence on the issue, when considered along with the goals and objectives of ERISA, indicates that the Louisiana Assignment Statute should not be preempted by ERISA.

Blue Cross also argues that a recent Supreme Court case, *Egelhoff v. Egelhoff*, mandates a finding of ERISA preemption in the instant case. At issue in *Egelhoff* was a Washington statute that provided that the designation of a spouse as the beneficiary of a nonprobate asset (which included employee benefit plans) would be automatically revoked upon divorce. *Egelhoff v. Egelhoff, ex rel. Breiner*, 532 U.S. 141, 121 S.Ct. 1322, 149 L.Ed.2d 264 (2001). The Supreme Court held that ERISA preempted the state beneficiary designation statute to the extent it applied to ERISA plans. *Id.* at 147, 121 S.Ct. 1322. The statute required ERISA plan administrators to pay beneficiaries chosen by state law, rather than the beneficiaries identified in the plan documents. Therefore, the Court concluded that the

statute had an impermissible connection with ERISA plans because it bound plan administrators to a particular choice of rules for determining beneficiary status. *Id.* at 147, 121 S.Ct. 1322.

Blue Cross asserts that the Louisiana Assignment Statute, like the statute at issue in *Egelhoff*, purports to bind an ERISA plan administrator to a particular choice of rules concerning the payment of benefits. However, this court does not agree and instead finds that *Egelhoff* does not require a finding of preemption in this case. In *Egelhoff*, the Court found that the state statute was preempted because it violated ERISA's requirement that the plan be administered "in accordance with the documents and instruments governing the plan," making payments to a "beneficiary" who is "designated by a participant, or by the terms of [the] plan." *Id.* at 147, 121 S.Ct. 1322; *see also* 29 U.S.C. § 1104(a)(1)(D); *see also* 29 U.S.C. § 1002(8). The Washington statute at issue in *Egelhoff* provided that a plan participant's designation of a beneficiary would automatically be invalidated by operation of state law, without any affirmative act by the participant, and in spite of any existing designation in the documents and instruments governing the plan. Therefore, the statute effectively allowed the state of Washington to designate the beneficiary to receive plan benefits, in contravention of ERISA.

However, the Louisiana Assignment Statute is different because it does not invalidate, revoke, or alter a plan participant's designation of a beneficiary. A "beneficiary" is "a person [2] designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." *See* 29 U.S.C. § 1002(8). An assignment of benefits is a designation of a beneficiary by a

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[2] Under 29 U.S.C. § 1002(9), the term "person" includes natural persons and juridical persons such as corporations and other entities.

plan participant as contemplated by ERISA's definition of "beneficiary." This is because a participant's assignment of benefits to his health care provider makes the assignee a person who is "entitled to a benefit" under the plan. *Kennedy v. Connecticut General Life Ins. Co.*, 924 F.2d 698, 700 (7th Cir.1991). Such a designation is expressly permitted by ERISA. The Louisiana Assignment Statute only becomes applicable when a plan participant has made such an affirmative designation, through the assignment of his benefits. Therefore, the statute does not allow the state of Louisiana to designate the beneficiary, as occurred in *Egelhoff*, but rather the Assignment Statute honors a designation made by a participant, as expressly contemplated by ERISA.

*657 Because ERISA already requires Blue Cross, as a plan administrator, to make payments to a beneficiary designated by a plan participant, the Louisiana Assignment Statute does not conflict with ERISA. At most, the statute has only an indirect economic effect on ERISA plans because it takes away some of Blue Cross' bargaining power when negotiating to attract new health care providers to join its network. Such an indirect economic effect is not sufficient to justify a finding that the statute "relates to" an ERISA plan. See *Travelers*, 514 U.S. at 668, 115 S.Ct. 1671.

Therefore, after considering the intent and purpose of ERISA as well as the nature of the effect that the Louisiana Assignment Statute has on ERISA plans, the court finds that ERISA does not preempt the Louisiana Assignment Statute, La. R.S. 40:2010, as applied to employee benefit plans insured or administered by Blue Cross.

Furthermore, the court finds that the language of Blue Cross' health care plans requires that Blue Cross honor a patient's assignment of benefits. This is because the anti-assignment

provisions in the Blue Cross plans state that assignments of benefits will not be honored "except as required by law." ERISA is silent on the issue of assignment of health care benefits, and therefore, "except as required by law" must necessarily refer to requirements of state law, including Louisiana's requirement in La. R.S. 40:2010 that assignments of benefits are honored.

Moreover, Blue Cross' policies issued in Louisiana contain a clause providing that any policy term that conflicts with state law is amended to conform to state law. As a result, Blue Cross' anti-assignment provision is automatically amended, by the terms of the policy, to conform to the requirements of the Louisiana Assignment Statute, and Blue Cross is required to honor assignments of benefits.

Accordingly, the motion for summary judgment (doc. 50) filed by the plaintiff, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana, is hereby DENIED.

APPENDIX D
ORDER OF THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT
DENYING PETITION FOR REHEARING *EN BANC*
SEPTEMBER 15, 2006

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

No. 04-31114

LOUISIANA HEALTH SERVICES & INDEMNITY CO., doing business as Blue Cross Blue Shield of Louisiana

Plaintiff - Intervenor Defendant - Appellant

v.

RAPIDES HEALTHCARE SYSTEM; STATE OF LOUISIANA; CHARLES R FOTI JR, Attorney General for the State of Louisiana;

Defendants - Appellees

v.

DAUTERIVE HOSPITAL

Intervenor Plaintiff - Appellee

Appeal from the United States District Court for the Middle District of Louisiana, Baton Rouge.

ON PETITION FOR REHEARING EN BANC

(Opinion 8/16/06, 5 Cir., _____, _____ F. 3d _____)

Before HIGGENBOTHAM, DeMOSS, and OWEN, Circuit Judges.

PER CURIAM:

(X) Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Panel Rehearing is DENIED. No member of the panel nor judge in regular active service of the court having requested that the court be polled on Rehearing En Banc (FED. R. App. P. and 5th CIR. R. 35), the Petition for Rehearing En Banc is DENIED.

( ) Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Rehearing is DENIED. The court having been polled at the request of one of the member of the court and a majority of the judges who are in regular active service and not disqualified not having voted in favor (FED. R. APP. P. and 5th CIR. R. 35), the Petition for Rehearing En Banc is DENIED.

ENTERED FOR THE COURT

/s/ Higginbotham
United States Circuit Judge

APPENDIX E
JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT, ISSUED AS MANDATE SEPTEMBER 25, 2006

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

No. 04-31114

Docket No. 3:00-CV-694-D

LOUISIANA HEALTH SERVICES & INDEMNITY CO., doing business as Blue Cross Blue Shield of Louisiana

Plaintiff - Intervenor Defendant - Appellant

v.

RAPIDES HEALTHCARE SYSTEM; STATE OF LOUISIANA; CHARLES R FOTI JR, Attorney General for the State of Louisiana;

Defendants - Appellees

v.

DAUTERIVE HOSPITAL

Intervenor Plaintiff - Appellee

Appeal from the United States District Court for the Middle District of Louisiana, Baton Rouge.

Before HIGGINBOTHAM, DeMOSS, and OWEN, Circuit Judges.

JUDGMENT

This cause was considered on the record on appeal and was argued by counsel.

It is ordered and adjudged that the judgment of the District Court is affirmed.

IT IS FURTHER ORDERED that appellant pay to appellees the costs on appeal to be taxed by the Clerk of this Court.

OWEN, Circuit Judge, concurs.

ISSUED AS MANDATE: SEP 25 2006

APPENDIX F
UNITED STATES CONSTITUTION, ARTICLE VI, CLAUSE 2

This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the Judges in every State shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding.

APPENDIX G
ERISA PROVISIONS

29 U.S.C. § 1002. Definitions

For purposes of this subchapter:

. . . . (8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

. . . .

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29 U.S.C. § 1102. Establishment of plan

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument.

. . . .

(b) Requisite features of plan

Every employee benefit plan shall--

. . . . (4) specify the basis on which payments are made to and from the plan.

29 U.S.C. § 1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and--

. . . .

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

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29 U.S.C. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or

fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

. . . .

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

. . . .

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

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29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust

established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

. . . .

APPENDIX H
LA. REV. STAT. ANN. § 40:2010

LOUISIANA REVISED STATUTES
TITLE 40. PUBLIC HEALTH AND SAFETY
CHAPTER 11. STATE DEPARTMENT OF HOSPITALS
PART I. ORGANIZATION AND POWERS

§ 2010. Itemized statement of billed services by hospitals

Not later than ten business days after the date of discharge, each hospital in the state which is licensed by the Department of Health and Hospitals shall have available an itemized statement of billed services for individuals who have received the services from the hospital. The availability of the statement shall be made known to each individual who receives service from the hospital before the individual is discharged from the hospital, and a duplicate copy of the billed services statement shall be presented to each patient within the specified ten day period. No insurance company, employee benefit trust, self-insurance plan, or other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered by the hospital shall pay those benefits to the individual when the itemized statement submitted to such entity clearly indicates that the individual's rights to those benefits have been assigned to the hospital. When any insurance company, employee benefit trust, self-insurance plan, or other entity has notice of such assignment prior to such payment, any payment to the insured shall not release said entity from liability to the hospital to which the benefits have been assigned, nor shall such payment be a defense to any action by the hospital against that entity to collect the assigned benefits. However, an interim statement shall be provided when requested by the patient or his authorized agent.

APPENDIX I
BLUE CROSS SAMPLE PLAN EXCERPT: DIRECT PAYMENT PROVISION

Direct Payment to Member

1. All benefits payable by the Company under this Benefit Plan and any amendment hereto are personal to the Member and are not assignable in whole or in part by the Member. The Company has the right to make payment to a Hospital, Physician, or other Provider (instead of to the Member) for Covered Services which they provide while there is in effect between the Company and any such Hospital, Physician, or other Provider an agreement calling for the Company to make payment directly to them. In the absence of such an agreement for direct payment, the Company will pay to the Member and only the Member those Benefits called for herein and the Company will not recognize a member's attempted assignment to, or direction to pay, another, except as required by law.

2. Hospitals, Physicians, and other Providers which have agreed with the Company or another Blue Cross and Blue Shield Benefit Plan for such direct payment are, by reason of such agreements, "Participating Hospitals," "Participating Physicians" (often called "Key Physicians"), or "Participating other Providers," respectively, and are referred to collectively as "Participating Providers." Those Hospitals, Physicians, and other Providers which do not have such agreements for direct payment are "Nonparticipating Hospitals," "Nonparticipating Physicians," and "Nonparticipating other Providers," respectively, and are referred to collectively as "Nonparticipating Providers."

3. If the Company has offered a Hospital, Physician, or other Provider an agreement for direct payment by the Company, but there is no such arrangement in effect when Covered Services are rendered to a Member by such Hospital, Physician, or other Provider, the Company will not recognize a Member's attempted assignment to, or direction to pay, such Hospital, Physician, or other Provider. The Company will pay to the Member and only the Member those Benefits called for in this Benefit Plan and any amendment thereto.